MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11424 — Reg. Dist. No. 11406

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 25 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL — DEER PARK
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
RAY	C	ASHBY	OCTOBER	5	1959

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	NEVER MARRIED ☒	AUG. 31, 1897	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MINER	COAL	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN ASHBY	MINNIE SHAFFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes	WW I	213-10-3714	MINERVA MAE ASHBY	R # 1 — DEER PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 Days
DUE TO
(b):
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 10-5, 1959 to 10-5, 1959, that I last saw the deceased alive on 10-5, 1959, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E. Mance M.D. — ADDRESS (Street, city or town, state): Oakland — DATE SIGNED: 5 Oct 59

PHYSICIAN'S NAME (Type): ANDREW E. MANCE, M.D. — OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
burial	10/7/1959	Terra Alta Cemetery	Terra Alta W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Minnich Funeral Home	Oakland Maryland	OCT 13 '59	Arthur E. Mance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11425 CERTIFICATE OF DEATH

Reg. Dist. No. 11407

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 2 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SWANTON
d. STREET ADDRESS: ROUTE # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JESSE Middle HAMILTON Last BROOKS

4. DATE OF DEATH: Month OCTOBER Day 14 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 8/20/1875

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WOODSMAN

10b. KIND OF BUSINESS OR INDUSTRY: LUMBER

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE BROOKS

14. MOTHER'S MAIDEN NAME: JANE MC ROBIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-0467

17. INFORMANT: FLOSSIE L. LIKENS Address: MT. LAKE PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial heart disease C	
DUE TO	422.1	3 days
(b)	Suffocation by Failure	
DUE TO	Esophageal ulcer	
(c)	arteriosclerosis	10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 29, 1959 to 10-14, 1959, that I last saw the deceased alive on 10-14, 1959, and that death occurred at 2:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E Mance M.D. ADDRESS (Street, city or town, state): Oakland Md DATE SIGNED: 15 Oct 59

PHYSICIAN'S NAME (Type): ANDREW E. MANCE, M.D. THIRD STREET OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/17/1959

22c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery

22d. LOCATION (City, town, or county) (State): Deer Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H C Langfelder ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: OCT 20 '59

24b. REGISTRAR'S SIGNATURE: Andrew E. Mance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11426

Reg. Dist. No. 11408

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 72 Alder Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland,
d. STREET ADDRESS: 72 Alder Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine Kimmell Middle: Last: Browning

4. DATE OF DEATH: Month: October Day: 22, Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1881

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chauncey Kimmell

14. MOTHER'S MAIDEN NAME: Harriett Sinclair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: --

17. INFORMANT: T. A. Kimmell Address: Mt. Lake Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH:

420.0

DUE TO (b): Arteriosclerosis — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 22, 19 59 to Oct. 22, 19 59 that I last saw the deceased alive on Oct. 22, 19 59, and that death occurred at 7:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E Mance M.D. ADDRESS (Street, city or town, state): Oakland DATE SIGNED: 23 Oct 59

PHYSICIAN'S NAME (Type): Andrew E. Mance, M. D. Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: 10/25/1959 22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery 22d. LOCATION (City, town, or county) (State): Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. G. Leighton ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: OCT 30 '59 24b. REGISTRAR'S SIGNATURE: Arthur S. Knowles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11427

CERTIFICATE OF DEATH

11409 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Grantsville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Garrett
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): X Rural Grantsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
WILSON	HENRY	BUTLER	Oct.	1	1959

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Oct. 29, 1897	62 61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Garrett Co., Roads	Garrett Co., Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
McClian Butler	Eliza Folk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
	213-18-2630	Mrs. Gladys Butler, RD #2, Grantsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sarcomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mo,
DUE TO (b): Reticulo-cell sarcoma jejunum — 1 yr
DUE TO (c):

200.0

Conditians, if ony, which gove rise ta immediate couse (o), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	July 59			Sept 26 59		

21. I **certify** that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive an Sept. 26, 19 59, and that death occurred at 10:10 M, from the causes and an the date stated abave.

ACTUAL SIGNATURE: Ross Rumbaugh M.D. — ADDRESS (Street, city or tawn, stote): Meyersdale, Pa. — DATE SIGNED: 10-2-59

PHYSICIAN'S NAME (Type) Ross Rumbaugh

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or caunty) (Stote)
Burial	10/4/59	Trinity Reform	New Germany, Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Don J Newman	Grantsville, Md/	OCT 6 '59	Arthur L Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, ar removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11410

CERTIFICATE OF DEATH

11428

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lives in Garrett Co., Maryland
Mailing address: Wilson, W. Va.
d. STREET ADDRESS: Box 64
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Howard — Middle: Elsworth — Lost: Cosner

4. DATE OF DEATH: Month: October — Day: 15 XX — 1959 XX

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 11 1882

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Daniel Francis Cosner

14. MOTHER'S MAIDEN NAME: Maggie Cosner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: "Wife" Zela Lena Cosner — Address: Box 64 Wilson, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured, Saccular, Aortic — INTERVAL BETWEEN ONSET AND DEATH:
451X
DUE TO
(b): Aneurysm — 2 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerosis — 8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 10-15-59, 19 59, and that death occurred at 6:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E. Mance M.D. — ADDRESS (Street, city or town, state): Oakland Md — DATE SIGNED: 15 Oct 59

PHYSICIAN'S NAME (Type): Andrew E. Mance, M. D., Oakland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 18, 1959
22c. NAME OF CEMETERY OR CREMATORY: Locust Grove
22d. LOCATION (City, town, or county) (State): Bismark, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Wayne C. Spiggle — ADDRESS: Davis, W.Va.

24a. REC'D BY REGISTRAR — DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Circling & Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11411

11429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 41 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ~~OAKLAND~~ Mt. Lake Park,
d. STREET ADDRESS: ~~P.O. BOX #108~~ Loch Lynn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DELLA — Middle Nordeck — Last CRANE

4. DATE OF DEATH: Month OCTOBER — Day 4 — Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC. 18, 1881

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOMEMAKER

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CHRISTOPHER NORDECK

14. MOTHER'S MAIDEN NAME: MARY CATHERINE MOORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): UNKNOWN (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT — Address: FERNE C. WELCH, LOCH LYNN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 13 days
DUE TO
(b): Arteriosclerotic Cardio Vascular Disease Unknown — 422.1
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of right hip - February 1959

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1959 to OCT. 4, 1959, that I last saw the deceased alive on October 4, 1959, and that death occurred at 10:12 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St, Oakland Md. — DATE SIGNED: 4 Oct 59

PHYSICIAN'S NAME (Type): Dr. Herbert H. Leighton, M.D. Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/7/1959
22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
22d. LOCATION (City, town, or county) (State): Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. C. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG251 10-30-59 et

11430

CERTIFICATE OF DEATH

11412

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Friendsville Md
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: OKIE — Middle: S. — Last: FRIEND

4. DATE OF DEATH: Month: 10 — Day: 22 — Year: 1959

5. SEX: M.

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-4-1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timber Worker

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wm H. Friend

14. MOTHER'S MAIDEN NAME: Eliza J. Umbel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 210-09-8368

17. INFORMANT — Address: Mrs Edna Friend. Friendsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Failure
DUE TO (b): Bronchogenic Carcinoma
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Artery Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-3-, 1959 to 10-22-, 1959, that I last saw the deceased alive on 10-22-, 1959, and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Pedro Rivera M.D. ADDRESS (Street, city or town, state): Friendsville, Md DATE SIGNED: 10-23-59

PHYSICIAN'S NAME (Type): PEDRO RIVERA Friendsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-25-59

22c. NAME OF CEMETERY OR CREMATORY: Blooming Rose Cem

22d. LOCATION (City, town, or county) (State): Friendsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H H Rodaheaver - Martinsburg Pa

24a. REC'D BY REGISTRAR DATE: OCT 26 '59

24b. REGISTRAR'S SIGNATURE: Carlton S. Hobbs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

212-09-2363

Cardio Respiratory Failure

Bronchogenic Carcinoma

Coronary Artery Disease

I hereby certify that I attended the deceased from 8-5-, 19 57 to 10-22, 19 57, that I last saw him alive on 10-22, 19 57, and that death occurred at 9 PM

Friendsville, Md 10-23-57

Pedro Rivera Friendsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431

CERTIFICATE OF DEATH

11413

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CRELLIN
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First KIMBERLY — Middle — Last GUTHRIE

4. DATE OF DEATH: Month OCTOBER — Day 21 — Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 29, 1959

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months 1 Days 22 IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LEROY JOSEPH GUTHRIE

14. MOTHER'S MAIDEN NAME: BABARA LOUISE STRAWSER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Address —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MALNUTRITION — INTERVAL BETWEEN ONSET AND DEATH: 12 days
571.0
DUE TO
(b): Vomiting and Diarrhea — 12 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from Aug 29, 1959, to Oct 21, 1959, that I last saw the deceased alive on Oct 21st, 1959, and that death occurred at 8:35A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James W. Feaster, Jr. M.D. — ADDRESS (Street, city or town, state): 58 21 st OAKland, Md — DATE SIGNED: 10-21-59

PHYSICIAN'S NAME (Type): JAMES H. FEASTER, JR, M.D. — OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): burial — 22b. DATE THEREOF: 10/23/59 — 22c. NAME OF CEMETERY OR CREMATORY: Ashby Cemetery — 22d. LOCATION (City, town, or county) (State): Crellin Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Minnich Funeral Home Oakland, Maryland — 24a. REC'D BY REGISTRAR DATE: OCT 27 '59 — 24b. REGISTRAR'S SIGNATURE: Carlton E Frank

2070172XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11432 — Reg. Dist. No. 11414

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grantsville, Md.
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Grantsville, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Terry — Middle: Lynn — Last: Kinsinger
4. DATE OF DEATH: Month: Oct. — Day: 12 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 12, 1959
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 3 — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Meyersdale, Somerset Co., Pa. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Owen Kinsinger
14. MOTHER'S MAIDEN NAME: Virginia Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. Owen Kinsinger, Grantsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 10-15 Min
DUE TO (b): Inability to roll over in bed
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
9240

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Dislocation of right knee
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Found dead in bed
20c. TIME OF INJURY Hour: 11:00 o. m. p. m. — Month, Day, Year: Oct. 11 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Grantsville, Garrett, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Feaster, Jr. M.D.
EXAMINER'S NAME (Type): James H. Feaster, Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-12-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 14, 59
22c. NAME OF CEMETERY OR CREMATORY: Grantsville
22d. LOCATION (City, town, or county) (State): Grantsville, Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Don Newman
ADDRESS: Grantsville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11433

CERTIFICATE OF DEATH

11415

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Oakland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First John; Middle; Last Kriner

4. DATE OF DEATH: Month October; Day 20; Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 6/16/94

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Kriner (Krynock), Joseph

14. MOTHER'S MAIDEN NAME: Chervenko, ~~Maxx~~ Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): War 1

16. SOCIAL SECURITY NO.: 232-26-8229

17. INFORMANT: Mr. Wayne Hamilton — Address: Oakland, Md. Rt#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b): Arteriosclerotic Cardio Vascular Disease Unknown
DUE TO
(c):

420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 18, 1959 to Oct 20, 1959, that I last saw the deceased alive on October 20, 1959, and that death occurred at 12:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D.
ADDRESS (Street, city or town, state): 77 Oak St. Oakland, Md.
DATE SIGNED: 20 Oct 59

PHYSICIAN'S NAME (Type): Herbert H. Leighton, M.D. Oakland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-23-59
22c. NAME OF CEMETERY OR CREMATORY: Baptist
22d. LOCATION (City, town, or county) (State): Buckhannon W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Wayne C. Spiggle
ADDRESS: Davis, W.Va.

24a. REC'D BY REGISTRAR DATE: OCT 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11434 — Reg. Dist. No. 11416

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 9 hrs. 47 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MT. LAKE PARK
d. STREET ADDRESS: Loch Lynn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINNIE — Middle Ellen — Last MORGAN

4. DATE OF DEATH: Month OCTOBER — Day 18 — Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 24 1898

9. AGE (In years last birthday): 59 (60) yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SUMMERS KUHN

14. MOTHER'S MAIDEN NAME: TOBITHA SHILLINGBURG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: NELLIE WEIMER, MT. LAKE PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Instantaneous
DUE TO
(b): Arteriosclerotic Cardiovascular Disease — Unknown
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 14, 1959 to Oct. 18, 1959, that I last saw the deceased alive on October 17, 1959, and that death occurred at 2:32 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St, Oakland, Md. — DATE SIGNED: 18 Oct 59

PHYSICIAN'S NAME (Type): DR. HERBERT LEIGHTON, M.D. — OAKLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/20/1959
22c. NAME OF CEMETERY OR CREMATORY: Pleasant Valley Cem.
22d. LOCATION (City, town, or county) (State): near Mt. Lake Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 20 '59
24b. REGISTRAR'S SIGNATURE: Carlton L. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11435

CERTIFICATE OF DEATH

11417
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × DEER PARK
d. STREET ADDRESS: ROUTE # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY GIRL "A" — Middle: — Last: PAUGH

4. DATE OF DEATH: Month: OCTOBER — Day: 26 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 26, 1959

9. AGE (In years last birthday): -- yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 1 — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES J. PAUGH

14. MOTHER'S MAIDEN NAME: BETTY JANE DILSWORTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: CHARLES J. PAUGH — Address: R #1 -DEER PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
762.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Fetal Immaturity — 1 hour
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Maternal Polyhydramnios

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 26, 1959, to Oct 26, 1959, that I last saw the deceased alive on Oct. 26, 1959, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St. Oakland, Md — DATE SIGNED: 27 Oct 59

PHYSICIAN'S NAME (Type): HERBERT H. LEIGHTON, M.D. — OAK STREET - OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/29/1959
22c. NAME OF CEMETERY OR CREMATORY: Ferndale Cemetery
22d. LOCATION (City, town, or county) (State): near Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md

24a. REC'D BY REGISTRAR DATE: NOV 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2170193 XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11436

CERTIFICATE OF DEATH

11418

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 7 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X DEER PARK
d. STREET ADDRESS: ROUTE # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY GIRL "B" Middle: Last: PAUGH

4. DATE OF DEATH: Month: OCTOBER Day: 26 Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 26, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months | Days | Hours: 7 | Min.
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES J. PAUGH

14. MOTHER'S MAIDEN NAME: BETTY JANE DILSWORTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: CHARLES J. PAUGH Address: ROUTE # 1 DEER PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 762.5 Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 hours
DUE TO
(b): Fetal Immaturity — 7 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Maternal - Polyhydramnios

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 26, 1959, to Oct 26, 1959, that I last saw the deceased alive on Oct 26, 1959, and that death occurred at 5:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hubert H. Leighton M.D. ADDRESS (Street, city or town, state): 77 Oak Street, Oakland, Md. DATE SIGNED: 27 Oct 59

PHYSICIAN'S NAME (Type): HERBERT H. LEIGHTON, M. D. OAK STREET OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/29/1959
22c. NAME OF CEMETERY OR CREMATORY: Ferndale Cemetery
22d. LOCATION (City, town, or county) (State): near Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton
ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR DATE: NOV 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

22701 93XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11419

11437

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Cuppett Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, near Cumberland
d. STREET ADDRESS: Rt. 3, Keyser, W.Va.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLOTTE Middle MARTHA Lost RAVENSCROFT

4. DATE OF DEATH: Month October Day 24 Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 25, 1910

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Worked

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Avilton, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roland Dayton Ravenscroft

14. MOTHER'S MAIDEN NAME: Sarah Rosella Lancaster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Eddie Ravenscroft, Rt. 3. Keyser, West Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr

DUE TO (b): Hypertension — 3 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psycho neurosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to Oct 24, 1959, that I last saw the deceased alive on Oct 14, 1959, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. J. Baumgartner M.D. ADDRESS (Street, city or town, state): 25 ALDER ST DATE SIGNED: 10/24/59

PHYSICIAN'S NAME (Type): E. J. BAUMGARTNER OAKLAND MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 26, 1959

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 28 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom portion may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11438 11420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Garrett — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Frostburg

LENGTH OF STAY (in this place): LIFE

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Garrett

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--- Frostburg

STREET ADDRESS (If rural give location): Frostburg R.D. II

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Cordelia Priscilla Ravenscroft

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	Sept. 27, 1881	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	GARRETT Co- Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William A. Robeson	Fanny Blocher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	NONE	Mrs. Eleanor Chaney, LaVale, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 IMMEDIATE CAUSE (A)	Uraemia	10 days
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)	Myocarditis & Decompensation - Coronary	
DUE TO (C)	Arteriosclerosis	5 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr., 19 57, to Oct 28, 19 59, that I last saw the deceased alive on Oct 7, 19 59, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE: Alan R. Jarrett M.D. ADDRESS (Street, city, town, state): 236 Va. Ave Cumberland Md DATE SIGNED: 10/28/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	OCT. 30-59	BLOCHER CEMETERY	FROSTBURG RD Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
NOV 2 '59	Arthur L. Kraus	Stanley M. Howe, Salisbury Pa

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11421

Item 7 FilmG251 11-2-59 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY 11439 GARRETT
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEBER NURSING HOME
c. LENGTH OF STAY IN 1b 24 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MT. LAKE PARK, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
0102.2
d. STREET ADDRESS REAR 526 NECESSITY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print) First DAVID Middle Last RENNIE

4. DATE OF DEATH OCT. Month 21 Day 59 Year 19

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ Widowed

8. DATE OF BIRTH May 25, 1888

9. AGE (In years last birthday) 71 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Coal Miner

11. BIRTHPLACE (State or foreign country) Pekin, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Rennie

14. MOTHER'S MAIDEN NAME Jean McBeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address David E. Rennie Cumberland, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Coronary Sclerosis, Cardiac Hypertrophy ---

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Silicosis, Moderate

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE James H. Feaster, Jr. M.D.

EXAMINER'S NAME (Type) JAMES H. FEASTER, JR.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED Oct. 21, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct. 24, 1959

22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park

22d. LOCATION (City, town, or county) (State) Frostburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE OCT 26 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11422 Reg. Dist. No.

11440

1. PLACE OF DEATH
a. COUNTY Garrett MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville
c. LENGTH OF STAY IN 1b 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Friendsville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
George	Raymond	Schroyer	October	25,	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		Jan. 23, 1919	40 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	for others	Maryland.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Simon L. Schroyer	Myrtle Lowdermilk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
yes W W #2	214-01-9746	Mrs. Violet Schroyer Friendsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SKULL FRACTURE, MACERATION OF BRAIN — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

981×

DUE TO (b) GUN SHOT WOUND OF HEAD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Shot by Constable R. W. Guard of Friendsville, Md. as Constable was breaking up a fight.

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☒ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
12:15 a. m. p. m.	10-25-59 19		V.F.W BLDG.	FRIENDSVILLE GARRETT MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE James H. Feaster Jr. M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 10-25-59

EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/28/1959	Lutheran Cemetery	Accident, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
H. L. Leighton	Oakland, Md.	OCT 30 '59	Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11441

CERTIFICATE OF DEATH

11423

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Maryland~~ W. Va. b. COUNTY: Grant

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Lake Park,

c. LENGTH OF STAY IN 1b: 6 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bayard, 85 x 3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weber Nursing Home

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hattie Middle: Williams Last: Smith

4. DATE OF DEATH: Month: October Day: 6, Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 4, 1874

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Williams

14. MOTHER'S MAIDEN NAME: Alice Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Howard D. Smith Address: 895 McMullen Hwy., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombosis of Ventricle, Acute — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis, Generalized — 4 yrs
DUE TO
(c):

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-2-, 19 57 to 10-5-, 19 57, that I last saw the deceased alive on 10-5-, 19 57, and that death occurred at 8:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Feaster M.D. ADDRESS (Street, city or town, state): 558 2nd St. Oakland, Md. DATE SIGNED: 10-7-57

PHYSICIAN'S NAME (Type): James H. Feaster Jr., M. D. Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/8/1959

22c. NAME OF CEMETERY OR CREMATORY: Queens Point Cemetery

22d. LOCATION (City, town, or county) (State): Keyser, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: OCT 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11424

11442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Deer Park
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4 Mi. North Deer Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Deer Park,
d. STREET ADDRESS: 4 Mi. North Deer Park
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Ada Middle: Cecelia Last: Speicher
4. DATE OF DEATH: Month: October Day: 13, Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 28, 1886
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Charles Miller
14. MOTHER'S MAIDEN NAME: Mary Johnston
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Address: Kathryn Speicher R. D. Deer Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hypertensive Heart Disease	Years
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Diabetes Mellitus	5 years
DUE TO (c)	Arteriosclerosis	10 yrs.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1940 to October 13, 1959, that I last saw the deceased alive on October 13, 1959, and that death occurred at 9:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E Mance M.D. ADDRESS (Street, city or town, state): Oakland DATE SIGNED: 13 Oct 59

PHYSICIAN'S NAME (Type): Andrew E. Mance, M. D. Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/15/1959
22c. NAME OF CEMETERY OR CREMATORY: Paradise Church Cemetery
22d. LOCATION (City, town, or county) (State): near Deer Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton ADDRESS: Oakland, Md
24a. REC'D BY REGISTRAR DATE: OCT 20 '59
24b. REGISTRAR'S SIGNATURE: Andrew E Mance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1443 — Reg. Dist. No. 11425

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 3 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weeks Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York — b. COUNTY: Kings
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn 69X-3
d. STREET ADDRESS: 2046 East 28th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last Wheeler
4. DATE OF DEATH: Month October — Day 29, — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 18, 1868
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy Yard Worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wheeler
14. MOTHER'S MAIDEN NAME: Carrie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Wm. C. Rogers — Address: Mt. Lake Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure, Acute — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis, Generalized — YEARS
DUE TO (c): Senility — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Asthma
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959 to Oct 28th, 1959, that I last saw the deceased alive on Oct 28th, 1959, and that death occurred at 7:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Feaster
M.D.
ADDRESS (Street, city or town, state): Oakland, Md.
DATE SIGNED: 10-29-59
PHYSICIAN'S NAME (Type): James H. Feaster, Jr., M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 10/30/1959
22c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
22d. LOCATION (City, town, or county) (State): Brooklyn, New York.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton
ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR DATE: NOV 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57